

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6216 6-17-57 et

CERTIFICATE OF DEATH

06705

Reg. Dist. No.

6730

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 CENTREVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>BESSIE COOK BASSETT</u>				4. DATE OF DEATH Month Day Year <u>JUNE 7 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 15, 1873</u> 83 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN COOK</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH LYNCH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs. MARIE TURNER, CENTREVILLE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic valvular disease of the heart</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>May 5, 1957</u> to <u>June 7, 1957</u> , that I last saw the deceased alive on <u>June 6, 1957</u> , and that death occurred at <u>117 McTherson</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Centreville MD</u> DATE SIGNED <u>6/8/57</u>							
ACTUAL SIGNATURE <u>H. F. McTherson</u> M.D.				FURNITURE <u>6/8/57</u>			
PHYSICIAN'S NAME (Type) <u>H. F. McTherson</u>				<u>Centreville MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUN 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH HILL</u>		22d. LOCATION (City, town, or county) (State) <u>CHURCH HILL MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar J. Longmire</u>				ADDRESS <u>CHURCH HILL MD</u>		24a. REC'D BY REGISTRAR <u>JUN 13 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Elie Armatage</u>			

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06706

Reg. Dist. No.

254

6721

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>R</u> Last <u>BOYLES</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 8-1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>in Centerville Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Booker</u>		14. MOTHER'S MAIDEN NAME <u>Mary Council</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Robert Embert</u> Address <u>apt A-132 H. 91 Dup. Ave. Forest Hill Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/15</u> , 19 <u>57</u> , to <u>6/15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/15</u> , 19 <u>57</u> , and that death occurred at <u>1:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W Henry Fisher</u> M.D. <u>Centerville Md</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 18-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Centerville Md</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Howard Smith of Baltimore</u> ADDRESS <u>Centerville Md</u>		24a. REC'D BY REGISTRAR DATE <u>6/17/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Helen Wedridge</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

BUREAU V. S.

JUN 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Form 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6722

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item II FilmG218 7-18-57 et

Reg. Dist. No.

06702

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Nassau</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garden City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>168 Brixton Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Virginia Margaret Carroll</u>		4. DATE OF DEATH Month Day Year <u>June 3 19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9-1912</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>U.S.A. (State unknown)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cheese Roscoe Yelvington</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>1st. Lt. Vern Carroll--Quarters 602 B.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>434.2</u> DUE TO (b) <u>Asphyxiation attack + Heart attack</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Type) <u>REMOVED</u>		22b. DATE THEREOF <u>June 6</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Kane</u>		ADDRESS <u>Church Hill, Md.</u>	
24a. REC'D BY REGISTRAR <u>June 10 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elice Armstrong</u>	

NEW YORK STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 31

JUN 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6723

CERTIFICATE OF DEATH

06708

Reg. Dist. No. 251

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>				c. LENGTH OF STAY IN 1b <u>x 2</u> <u>Church Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Clay</u> Last <u>Coppage</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 30-1872</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farm Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Benjamin L. Coppage</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Rolph</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Alton B. Coppage--Church Hill, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic diseases due to heart</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerosis</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>421.4</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 31, 1957</u> , to <u>June 3, 1957</u> , that I last saw the deceased alive on <u>May 31, 1957</u> , and that death occurred on <u>June 3, 1957</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. F. McKenra</u> M.D.				DATE SIGNED <u>June 4, 1957</u>			
PHYSICIAN'S NAME (Type) <u>H. F. McKenra</u>				ADDRESS (Street, city or town, state) <u>Church Hill, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 5</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sudlersville</u>		22d. LOCATION (City, town or county) (State) <u>Sudlersville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Kane</u>				ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR <u>Edgar L. Kane</u>	
24b. REGISTRAR'S SIGNATURE <u>Edgar L. Kane</u>				DATE <u>JUN 10 1957</u>			

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 10 1957

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville Rural</u>		c. LENGTH OF STAY IN 1b <u>4 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Condova 20x22</u>	
3. NAME OF DECEASED (Type or print) First <u>Sallie</u> Middle <u>Wright</u> Last <u>Hopkins</u>		4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 21, 1867</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>19</u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Preston Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Stafford</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Wright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Emma B Hopkins</u>		Address <u>Easton, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, Generalised</u> DUE TO (c) <u>?</u> yrs.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> , 19 <u>57</u> , to <u>June</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>57</u> , and that death occurred at <u>11 A.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u>		DATE SIGNED <u>6/9/57</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>		ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 12, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Williams</u>		24a. REC'D BY REGISTRAR DATE <u>6-11-57</u>	24b. REGISTRAR'S SIGNATURE <u>Allen M. Uedridge</u>

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 8

JUN 14 1957

RECEIVED

1. DUTY MEDICAL EXAMINER: This certificate should be executed within 48 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6725

07827 254
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Queenstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Queenstown			
c. LENGTH OF STAY IN 1b Life				d. STREET ADDRESS Route 1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edward Jacobs				4. DATE OF DEATH Month Day Year 6 26 1957			
5. SEX Male		6. COLOR OR RACE Col		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/6/34	
9. AGE (in years last birthday) 22 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 22		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farmer			
13. FATHER'S NAME Joseph Jacobs				14. MOTHER'S MAIDEN NAME Laruel Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 779X Suicide - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH at once							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE W. Henry Fisher M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/57		22c. NAME OF CEMETERY OR CREMATORY Burrsville, Cem.		22d. LOCATION (City, town, or county) (State) Bentreville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Darrell, Corton, Md.				24a. REC'D BY REGISTRAR DATE 7/9/57		24b. REGISTRAR'S SIGNATURE Allen Aldridge	

MEDICAL CERTIFICATION

BUREAU V. S.

1952

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06710

6726

CERTIFICATE OF DEATH

Reg. Dist. No.

253

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dominion</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Dominion</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ANNIE</u> First <u>MAY</u> Middle <u>JURD.</u> Last				4. DATE OF DEATH <u>JUNE</u> Month <u>23</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 16, 1884</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WM ENIDRY MARSHALL</u>				14. MOTHER'S MAIDEN NAME <u>MAMIE JONES.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT <u>MRS THOMAS COLE, CENTERVILLE.</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u>							
DUE TO (b) <u>nephro-sclerosis hypertensive C.V.D.</u> 1 year?							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>large preperitoneal rectus hernia about 6 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>manic depressive Reaction (35 years)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>May 16, 1957</u> to <u>June 23, 1957</u> , that I last saw the deceased alive on <u>June 22, 1957</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodor Sattelmair</u> M.D.				ADDRESS (Street, city or town, state) <u>Stevensville Md.</u> DATE SIGNED <u>June 24, 57</u>			
PHYSICIAN'S NAME (Type) <u>THEODOR SATTELMAIER STEVENSVILLE Md.</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>STEVENSVILLE Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>				ADDRESS <u>CHURCH Hill, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6/25/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Elizabeth Hoyer</u>			

BUREAU V. S.

UN 17 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

0671151

6727

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - QUEEN ANNE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - QUEEN ANNE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FARM</u>				d. STREET ADDRESS <u>FARM</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>RICHARD</u> Last <u>MANDRELL</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 13, 1902</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FLETCHER MANDRELL</u>		14. MOTHER'S MAIDEN NAME <u>MARY BOYLES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>2-15-36-2399</u>		17. INFORMANT Address <u>MRS. MARY MANDRELL, QUEEN ANNE R.D. MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Dis.</u> DUE TO <u>with hypertension</u> (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>351X</u> <u>Rheumatoid Arthritis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Mar. 21</u> , 19 <u>57</u> , to <u>June 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 18</u> , 19 <u>57</u> , and that death occurred at <u>11:45 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u>						DATE SIGNED <u>6/20/57</u>	
ACTUAL SIGNATURE <u>Charles H. Stonesifer</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHESTERFIELD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CENTREVILLE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Stonesifer</u>				ADDRESS <u>CHURCH HILL</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 24 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edgar L. Stonesifer</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06712

6728

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

252

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>MASSEY</u> Last <u>MASSEY</u>				4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 26 - ?</u>		9. AGE (in years, if known) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>RTD Centerville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John J. Massey</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Ruth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-724-4896</u>		17. INFORMANT Name <u>Mr. Frances R. Russell, niece</u> Address <u>Chestertown Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion -</u> <u>420.1</u> DUE TO <u>Found dead in bed -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. J. Hearn, Fisher</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chestersfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Hearn, Fisher</u>				24a. REC'D BY REGISTRAR DATE <u>6/24/57</u>		24b. REGISTRAR'S SIGNATURE <u>Elmer Armstrong</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUN 28 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6729

CERTIFICATE OF DEATH

06713

Reg. Dist. No.

253

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>				c. LENGTH OF STAY IN 1b <u>50405</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>NONE</u>				e. STREET ADDRESS <u>NONE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH ELIZABETH MOORE</u>				4. DATE OF DEATH Month Day Year <u>JUNE 26 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 30, 1879</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>SAMUEL MOORE</u>		14. MOTHER'S MAIDEN NAME <u>MARY BABBURY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>MRS. MABEL E. BIKKENSTAEF</u> Address <u>CHESTER, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial insufficiency & coronary thrombosis</u> DUE TO <u>arteriosclerosis, hypertensive</u> <u>cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>chronic nephrosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic trophic ulcer right leg thrombophlebitis</u>							
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 14, 1957</u> to <u>June 26, 1957</u> , that I last saw the deceased alive on <u>June 25, 1957</u> , and that death occurred at <u>3:40 a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodor Sattelmair</u>		M.D.		ADDRESS (Street, city or town, state) <u>Stevensville, Md.</u>		DATE SIGNED <u>6/27/57</u>	
PHYSICIAN'S NAME (Type) <u>THEODOR SATTELMAYER STEVENSVILLE, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUN 28 '57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHESTERFIELD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CENTREVILLE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Longmire</u>				ADDRESS <u>Chester Hill, MD.</u>		24a. REG'D BY REGISTRAR DATE <u>June 28 '57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Elizabeth Hoster</u>			

BUREAU V. S.

JUL 2 1977

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, date of burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6730

CERTIFICATE OF DEATH

06714

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - CHURCH HILL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - CHURCH HILL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>MARY</u> Last <u>PARKER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 13, 1894</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ALBERT WATSON</u>		14. MOTHER'S MAIDEN NAME <u>WASHINGTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>CATHERINE PARKER, CHURCH HILL, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr. Glomerulo Nephritis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic Cardiovascular Dis.</u> DUE TO (c) <u>Chr. Myocarditis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Mar. 4, 1957</u> , to <u>June 20, 1957</u> , that I last saw the deceased alive on <u>June 19, 1957</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles H. Stonesifer, M.D.</u>				ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u>			
DATE SIGNED <u>6/20/57</u>							
PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>POND TOWN</u>		22d. LOCATION (City, town, or county) (State) <u>POND TOWN, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar J. Langston</u>				ADDRESS <u>CHURCH HILL, MD.</u>		24a. REC'D BY REGISTRAR <u>Edgar J. Langston</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edgar J. Langston</u>		DATE <u>JUN 24 1957</u>	

BUREAU V. S.

JUN 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 067157

6731

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route # 213				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) State Road between Church Hill Centreville				d. STREET ADDRESS 112 College Ave			
3. NAME OF DECEASED (Type or print) George (none) Sheppard, Jr.				4. DATE OF DEATH June 11, 1957			
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1939	
9. AGE (In years last birthday) 18 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Kent Co. Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Sheppard, Sr.				14. MOTHER'S MAIDEN NAME Elizabeth Lindsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-36-5973			
17. INFORMANT Catherine Moore Address 112 College Ave. Chestertown, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auto accident - Fractured skull DUE TO (b) + broken neck Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year 6/11-1957 Hour a. m. 1:15 p. m. ✓				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State highway				20f. (City or town) Centreville (County) 2nd (State) md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE W. Henry Fisher				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W. Henry Fisher				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF June 15, 1957			
22c. NAME OF CEMETERY OR CREMATORY Georgetown Cemetery				22d. LOCATION (City, town, or county) Chestertown, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.				24. MEDIC BY REGISTRAR JUN 14 1957 DATE			
				25. REGISTRAR'S SIGNATURE Grace W. W. W.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JUN 14 1957

RECEIVED

VS A1SME(S)
SM 9/55

06716

Reg. Dist. No. 262

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNES</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTREVILLE</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTREVILLE MD</u>	
		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Eugene Smailwood</u>		4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 24 1939</u>
9. AGE (In years, day, month, year) <u>17</u> yrs		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Ardell Smailwood</u>		14. MOTHER'S MAIDEN NAME <u>CORA Redmond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-36-1459</u>	
17. INFORMANT <u>Mr. R. J. Funkhouser</u>		Address <u>CENTREVILLE MARYLAND</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowned</u> DUE TO <u>Accidental Drowning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Jumped off the wharf and did not come up</u>	
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Quarry</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. F. McHenry</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. F. McHenry</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>6/1/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>June 4-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Georgetown</u>		22d. LOCATION (City, town, or county) (State) <u>Charles Town W Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Porter</u>		24a. REC'D BY REGISTRAR <u>6-4-57</u>	
ADDRESS <u>Centerville Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Elmer Armstrong</u>	

RECEIVED

UN 10 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6733

CERTIFICATE OF DEATH

06717

Reg. Dist. No.

254

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Hopper</u> Last <u>Stant</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31, 1901</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Stant</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Elliott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-41-7191</u>		17. INFORMANT <u>Mrs. Albert Stant</u>		Address <u>Queenstown</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Calcific Aortitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December, 1956</u> , to <u>June</u> , 1957, that I last saw the deceased alive on <u>May 29</u> , 1957, and that death occurred at <u>1:25</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin D. Hoyt</u>				ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u>		DATE SIGNED <u>6/3/57</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>June 6-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chestersfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard Barton</u>				ADDRESS <u>Barton Ber Centerville Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>6-4-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Helen M. Aldridge</u>			

BUREAU V. 4

JUN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6734

CERTIFICATE OF DEATH

0671851

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHURCH HILL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHURCH HILL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NONE</u>				d. STREET ADDRESS <u>NONE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS BENSON TATMAN</u>				4. DATE OF DEATH Month Day Year <u>JUNE 4 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 24, 1879</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE PAINTER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>GEORGE C. TATMAN</u>				14. MOTHER'S MAIDEN NAME <u>ANNA HURLOCK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			
17. INFORMANT <u>MARY R. MULLIKIN</u>				Address <u>CHURCH HILL, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Organic Heart disease with</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Kidney Complication</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Feb 1</u> , 19 <u>57</u> , to <u>June 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 31</u> , 19 <u>57</u> , and that death occurred at <u>4</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Henry Fisher</u>				ADDRESS (Street, city or town, state) <u>Centerville Md</u>			
DATE SIGNED <u>6/6-57</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 8, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CHURCH HILL MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. L...</u>				ADDRESS <u>CHURCH HILL, MD</u>			
24a. RECEIVED BY REGISTRAR <u>JUN 13 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Edgar L. L...</u>			

RECEIVED

JUN 10 1917

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6735

CERTIFICATE OF DEATH

Reg. Dist. No. 06719251

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill (Rural)		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD		e. STREET ADDRESS 1 RFD	
3. NAME OF DECEASED (Type or print) First Etta Middle F. Last Wilson		4. DATE OF DEATH Month June Day 11 Year 1957	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1876
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Queen Anne Co. Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ezekiel Asbury		14. MOTHER'S MAIDEN NAME Susan Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Anna Wright		Address Church Hill, Md. Rfd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary 420.1 DUE TO Found dead in bed Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Found dead in bed DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to 6/4 , 19 57 , that I last saw the deceased alive on _____, 19____, and that death occurred at 11 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Centreville, Md. DATE SIGNED 6/12/57			
ACTUAL SIGNATURE W. Henry Fisher M.D.		DATE SIGNED 6/12/57	
PHYSICIAN'S NAME (Type) W. Henry Fisher		Centreville Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 16, 1957	22c. NAME OF CEMETERY OR CREMATORY Rich Neck Hall Cem.	22d. LOCATION (City, town, or county) (State) near Church Hill, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		ADDRESS Chestertown, Md.	
24a. RECEIVED BY REGISTRAR JUN 14 1957		24b. REGISTRAR'S SIGNATURE Edgar L. Lutz	

CERTIFICATE OF DEATH

BUREAU V. B.

JUN 14 1957

RECEIVED

6736 CERTIFICATE OF DEATH

Reg. Dist. No.

254

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Grasonville</u>	
c. LENGTH OF STAY IN 1b <u>1 yr.</u>		d. STREET ADDRESS <u>1 Box 78A</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Etta</u> Last <u>Winchester</u>		4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/14/86</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Perry Foreman</u>		14. MOTHER'S MAIDEN NAME <u>Eric Anna Madden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>2</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Eric Anna Madden</u>	
17. INFORMANT <u>Ester Carroll</u>		Address <u>Grasonville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks -</u> <u>2 years -</u> <u>2 -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Apr. 17</u> , 19 <u>56</u> , to <u>June 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 8</u> , 19 <u>57</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>Millington, Md</u> DATE SIGNED <u>6-10-57</u>	
PHYSICIAN'S NAME (Type) <u>GEZA KORALEWSKI</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/13/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chestersfield Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Centerville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Blackhill</u>		ADDRESS <u>Eaton, Md.</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>JUN 13 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Name of Deceased		Date of Birth		Sex	
Name of Father		Date of Birth		Sex	
Name of Mother		Date of Birth		Sex	
Place of Birth		Date of Death		Cause of Death	
Occupation		Residence		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Certificate		Date of Entry		Date of Filing	

RECEIVED
JUN 13 1957
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